Summit Imaging
12037 Cortez Boulevard
Brooksville, Florida 34613
(352) 597-9008 • Fax: (352) 597-1008

PATIENT CONSENT FORM

Name: _____ **DOB:** _____

I have been referred by my physician to your facility for a(an) _____ .

I understand that the practice of medicine is not an exact science and no guarantee can be made as to the results that might be obtained from this procedure.

I understand that complications can occur. By consenting to this exam, I hereby consent to the necessary medical or surgical actions of the physician and/or colleagues, medical/surgical; whomever they choose to consult with to take appropriate actions in regard to this procedure should any complications occur during my visit. **Patient Initials:** _____

I, the undersigned, authorize Summit Imaging to use and disclose my information for the purposes of treatment, payment and healthcare operations as described in the Notice of Privacy Practices. (Available in our Waiting Room) I acknowledge that I have access to the Summit Imaging Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy official. **Patient Initials:** _____

I hereby acknowledge that Summit Imaging, employees and all affiliates do not assume responsibility for securing valuables or personal items belonging to patients or visitors. Although lockers may be available, they are intended only as a convenience and should not be considered secure.

I have read the above statement and understand that I am fully responsible for securing my valuable or personal items. I further acknowledge that this facility and its employees are not liable for the loss or theft of these items. **Patient Initials:** _____

Patient Financial Responsibility: I understand my financial responsibility and I guarantee payment for all charges not covered by my insurance, all applied deductibles and co-pays, within 30 days of receiving a statement. MEDICARE PATIENTS: I authorize to release medical information about me to the Centers for Medicare & Medicaid Services (CMS) or its intermediaries for my Medicare claims. I assign the benefits payable for services to Summit Imaging.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature: _____

Date: _____ **Witness:** _____